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PELVIC EFFUSIONS

AND THE

IMPORTANCE OF THEIR EARLY RECOGNITION WITH REFERENCE TO TREATMENT.

READ BEFORE THE OBSTETRICAL SOCIETY OF BOSTON.

BY

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PELVIC EFFUSIONS

AND THE IMPORTANCE OF THEIR EARLY RECOGNITION WITH REFERENCE TO TREATMENT. REPORT OF ELEVEN CASES.[1]

BY G. H. LYMAN, M. D.

A FEW months since I reported to the American Gynæcological Society one hundred and forty-six cases of pelvic effusions, of which forty-one resulted in abscess. These cases occurred at the Boston City Hospital during the preceding five years. During the last quarterly term of service, beginning October 1, 1881, eleven additional cases came under my charge, of which two were of puerperal origin, two were clearly sanguineous effusions, hematoceles, resulting in abscess, and the remainder were effusions the exact character of which can be surmised only from the records of them given below, some probably hæmorrhagic, but most of them either plastic exudations or simple serous effusions from pelvic cellulitis or peritonitis, for, as in many hospital cases, an exact positive differential diagnosis is often impossible, the antecedents obtainable, especially if they be at all chronic, being generally vague and indefinite, rendering it impracticable to ascertain whether a certain mass of pelvic effusion was of serous or sanguineous origin, unless by aspiration, or otherwise, the contents can be submitted to ocular examination.

As these cases were most of them in the wards at the same time, and comprised examples of acute recent effusion, both serous and sanguineous, older chronic

[1] Read before the Boston Obstetrical Society.

exudations, and puerperal cases, a rare opportunity was afforded the students to learn the causes and progress, the diagnosis and treatment, of this common affection from its very inception, as well as its various results of rapid absorption when recognized and treated early, or, when not coming under treatment until a later period, of plastic exudation with slower absorption, or, finally, suppuration and evacuation artificially or by spontaneous rupture into the bladder, groin, etc.

These different varieties of pelvic effusion may all, of course, result in suppuration, and become true pelvic abscess, but with reference to both prognosis and treatment, it is practically important to have the diagnosis as accurate as possible in any given case; a simple serous effusion, for instance, even though large in amount, ought to, and in the majority of cases does, recover rapidly, leaving the pelvic organs in a healthy condition for future service. This very fact indeed, is, I believe, a fruitful source of error in diagnosis, many a case of pelvic trouble, with pain, dysuria, rectal tenesmus and metrorrhagia, being attributed to cystitis, dysentery, or metritis, and the urgent symptoms being relieved no farther directions or attention is given to the sequelæ, until they come under observation, perhaps long after, as the result of some irritation which might have been avoided had the true nature of the case been recognized. A sanguineous effusion is often, likewise, rapidly absorbed, but as a rule not so rapidly as the former, and under unfavorable conditions, which are not anticipated by correct diagnosis, they are even more liable to suppuration, the earliest advent of which should be diligently watched, and met with surgical interference.

Puerperal cellulitis, on the contrary, either as the direct result of injury or from septic absorption after labor, is always a more tedious and grave affair in its immediate consequences, and certainly not less so in the ultimate condition of the sufferer when the discharge has ceased, as shown by the displacement of

organs, the firm adhesions of the pelvic tissues, inclosing here and there masses of exudation, which, under the obvious manifold conditions of irritation to which every woman's pelvis is liable, become the focus of renewed suppurative action. Indeed, it is questionable whether a woman ever recovers entirely from the effects of a bad pelvic abscess, until, at any rate, after the menopause.

It is quite too common to treat these cases as tending always to ultimate recovery, surgical interference being declared not only unnecessary, but even unwise. If by recovery is meant the cessation of suppuration, after a time, — almost always greatly protracted, — and the ability of the patient to resume in some measure her ordinary avocations, the statement may, perhaps, be accepted, but before pronouncing a patient well after one of these abscesses, it would be worth while to get her subsequent history for a few years. Every one who has had occasion to see much of these cases knows very well, not merely their liability to recurrence so long as any plastic exudation remains, as it almost invariably does in greater or less quantity for long periods, but the tedious history of months, often years, of pain, irritable bladder and rectum, painful coition, menorrhagia, metrorrhagia, and irremediable uterine displacements, to say nothing of the multiform reflex disturbances, which render existence almost a burden. Cases of spontaneous opening into the bladder or rectum often close with comparative comfort to the patient for long periods, only to reappear again under any unusual excitement. It is not in these cases so much a question of death, — although no mean percentage, especially of the puerperal variety, do result fatally, — but it is a question whether, as the result of early and accurate diagnosis, we may not much more often give such prompt relief as to preserve the normal relations and integrity of the parts, and so avoid this protracted discomfort and invalidism. We do not treat other affections, much less important, after this

expectant method. It would seem quite as rational to leave a bad mammary abscess to burrow on for months without any regard to the ultimate integrity of the gland, the protracted suffering, or the constitutional exhaustion.

If the great frequency of pelvic peritonitis, cellulitis, and hematocele were more generally recognized, and an early and discriminating diagnosis obtained before they had reached the period when such diagnosis becomes impossible, a larger proportion would be cut short before the stage of suppuration, or, having reached that stage, the damaging results to the pelvic viscera could, by early evacuation, be anticipated.

In some of the cases given it will be seen that early recognition and treatment were followed by prompt recovery in the proper meaning of that term. In others with an older history, and with large plastic exudations tending evidently to mischief, treatment was effectual in averting suppuration, affording a marked contrast to still others where spontaneous openings had occurred more than once in a period of years, and which, if more promptly recognized, might possibly have been prevented.

I do not assert, of course, that every case is amenable to arrest by surgical interference, for often neither fluctuation nor any signs of suppuration are discoverable to the most vigilant observation, but it is none the less true that many more occur where it is impossible to doubt that opportunities for relief by aspiration are missed because not carefully sought for. I would even go farther, and urge that where any reasonable doubt even of suppuration exists, aspiration be resorted to, especially as it has often happened in cases of failure to reach pus that the irritation of the needle has stimulated absorptive action in the indurated mass.

The causes, location, pathology, and diagnosis of these various pelvic effusions have been so exhaustively treated since 1850 (before which time little was

known with certainty), that I will not trespass to any extent upon your time by discussing them. Bernutz, Aran, Nélaton, Voisin, Scanzoni, Virchow, and others have written freely, some of them exhaustively. Many valuable contributions also have been made by English and American authors, which are familiar to all interested in the subject, and I will therefore content myself with a short summary of points generally recognized as most important to bear in mind, especially as to diagnosis and treatment.

The difference so much contended for between phlegmon or thrombus (outside the peritonæum) and hæmatocele (within the peritonæum) need be alluded to only so far as to state that the former, that is, the extra-peritoneal sanguineous effusions, generally obtain in puerperal cases, tending to external openings, as the groin, thigh, etc., — the latter, or intra-peritoneal, where suppuration follows, more often seek an outlet internally through the vagina, bladder, or rectum, or even, in rare cases, burst the adhesions above and escape into the abdominal peritonæum, menstruation playing a large part in their causation, though it is now well proved that blood may be extravasated at the catamenial periods into the cellular tissue beneath and external to the peritonæum, behind the uterus, or into the broad ligaments.

Pelvic peritonitis from defective or interrupted excretion is very common, hæmatocele from the same cause rare, so that too much stress is not to be laid in the diagnosis upon the fact of a coincidence between the catamenial period and the formation of the tumor. Bernutz [1] asserts that this would lead to error three times out of four, the reverse being true of "metrorrhagic hæmatoceles," as he calls them, where the flow from the uterus and the rapid formation of a tumor projecting into the abdomen above and the pelvis below, with the coincident symptoms of acute peritoneal

[1] Clinique Medicale sur les Maladies des Femmes, Paris, 1860-62, vol. ii., pp. 374 to 385.

irritation, are wholly unlike the slower formation of serous effusions and plastic exudation.

Hæmatoceles are rare in puerperal cases at term, pelvic peritonitis and cellulitis common, and usually terminating in suppuration.

In hæmatoceles the anæmia, the collapse, the rapid development, are usually characteristic as compared with the latter, the contrast modified by the rapidity with which the blood is poured out, that, for instance, from a ruptured tube or varix being of course more striking than the slower effusion from ovarian congestion or peritoneal hæmorrhagic exudation. Still, the diagnosis in those cases of pelvic peritonitis with effusion coexisting with metrorrhagia, will necessarily cause confusion which only careful observation of the order of the symptoms will clear up, especially the inversion in the order of their occurrence in the two cases respectively, hæmatoceles from any cause being accompanied first by the effusion and pain, then a rapid development of the tumor, reaching, in extreme instances, to and beyond the umbilicus, thirdly, anæmia, possibly collapse, and lastly the development of febrile symptoms, while, on the contrary, in the effusions from peritonitis and cellulitis we have first the febrile symptoms, then a gradual and more limited effusion, generally but not always confined to the pelvis, an absence of anæmia and collapse, and lastly the ordinary signs at a later period, of suppuration, should such a termination not be averted.

The difficulty of obtaining the relative order of the symptoms in many hospital cases, arising from lack of intelligence or of memory in the patient, and especially where the disease is already of some duration, renders, as I have already said, accurate diagnosis frequently impossible. In this connection it should not be forgotten that the two affections may coexist. Bernutz gives such cases. Cases also occasionally arise where neither menstrual irregularities, pain, the rapid development, the vaginal touch, the extension above the pubes,

etc., can be wholly relied on. Voisin (de L'Hæmatocele, page 180) gives the history of such a case in which Nélaton himself mistook a purulent collection from peritonitis for a hæmatocele. See, also, Bernutz on diagnosis of pelvic peritonitis and hæmatocele. (Vol. II.)

The results obtained from vaginal examination, also, are entirely unlike in the two cases. In hæmatocele the mass is reached often with difficulty, is more apt to be central, — yields at first a doughy, boggy feeling, and is often free from pain when touched, while in pelvic peritonitis, on the other hand, the vagina is hot, the swelling excessively sensitive, more lateral, dense and inelastic, and rarely rising above the pubes, being limited by the peritoneal adhesions resulting from the initial inflammation.

In hæmatocele menorrhagia is usual, especially in the earlier stages, and the tumor, after absorption commences, is said by Voisin[1] to decrease markedly with each monthly period; serous or plastic effusions, on the contrary, though metrorrhagia is very common in them, are neither influenced at first, or affected subsequently, by the monthly flow, which often recurs normally throughout.

I am quite aware that much of the foregoing is perfectly familiar to most of those present, but I have thought that in view of the recent discussion in this Society of the subject of puerperal pelvic abscess, these cases and the remarks suggested by them might be of sufficient interest to justify their presentation. I wish again to reiterate that, notwithstanding the objections made by some of the highest authorities, an early exploration of such effusions when suppuration is impending is, in my judgment, not only advisable when practicable, but is absolutely demanded for the ultimate well-being of the patient. I repeat that it is not so much a question of death as it is a question between partial recovery with all the organs in an abnormal

[1] Voisin de L'Hématocèle, Paris, 1860, page 164.

condition, and entire restoration anatomically and functionally. The let-alone policy certainly would not be thought justifiable in parallel surgical affections, examples of which will readily enough suggest themselves.

Case I. *Acute Effusion following Injury; Probably Sanguineous, with Secondary Local Peritonitis.* — J. P., thirty-three, married, entered hospital December 14th; never had children or miscarriages, menses always regular. Three weeks since, and one week after cessation of menses, she fell down stairs. This was followed by pain in standing or walking. A few days subsequently she had a rigor and has since had several chills, but neither vomiting or fever at the time. Defecation painful, micturition frequent, urine thick and reddish, anorexia, headache, insomnia, and slight bloody leucorrhœa since injury. Says the pain grows constantly worse. Vaginal examination shows a large effusion to the right of the uterus. Cervix not displaced, but uterus not movable. Under fomentations, rest, and opiates, she was made comfortable, and in two weeks (December 31st) she was nearly free from pain, the effusion rapidly diminishing, and the uterus more movable. No signs of suppuration.

January 15th. Nearly well of the pelvic trouble and remains in hospital for chronic pulmonary disease.

Note. The normal position of the cervix with such an effusion is noteworthy, and also the lateral position of the tumor. The reddish urine was probably from admixture with the vaginal discharge. From the early history dislocation of the uterus might have been anticipated, but nothing of the kind was found.

Case II. *Hæmatocele; Rapid Absorption.* — S. W., age twenty, entered October 18th, married one year, never pregnant, menses always regular and free. Has been sick in bed two weeks. Without any known cause was attacked with sudden pain and flowing, one week after cessation of catamenia. The hæmorrhage

continued copiously for a week, and then ceased, but the pain still continued, extending above the pubes — has pelvis tenesmus, increased by micturition, has chilly sensations but no positive chill, — has never had such an attack before.

October 18th. Vaginal examination shows the uterus to be fixed, the cervix wedged against the symphysis and a mass of effusion behind the uterus extending mostly to the right. Under treatment this rapidly absorbed and on the 31st a collar-like cellular infiltration, hard and free from pain and encircling the cervix, was all that remained.

November 2d. Was discharged at her own request with such cautions as to the slight induration remaining as seemed necessary.

Case III. *Pelvic Peritonitis.* — C. H., twenty-two, married, entered November 3d, one child eleven months previously, menses always regular, no leucorrhœa, no miscarriages. Five months ago and six months after her labor, wet her feet while menstruating — had menorrhagia, pain in pelvis and down right leg with vomiting, abdominal tenderness, and leucorrhœa, but neither rigors nor dysuria — was confined to her bed for a week, after which was up and about but unable to work. Three weeks before entrance took to her bed again with a renewal of all the symptoms and an increase of the fever and pain. The last attack came on during a menstrual interval.

November 4th. Vaginal examination revealed an effusion in Douglas's pouch extending down the recto-vaginal septum with a deep sulcus between it and the cervix. The uterus fixed, some tenderness in the right groin, but no hardness above the pubes. Uterus three inches deep, the sound passing to the right.

November 12th. Effusion much diminished and the pain has ceased.

November 13th. Patient sat up yesterday and to-day has had two rigors, continuous vomiting and severe epigastric pain.

November 16th. Universal tenderness, and micturition painful.

November 18th. Much improved, the pain has ceased, and the pulse and temperature are normal.

November 22d. Still improving, the effusion is absorbing rapidly, no tenderness, and uterus more movable.

December 6th. Effusion nearly gone. There remains a small ridge to the right of the cul-de-sac and on the left a dense, hard ridge extends from the side of the pelvis to the junction of the cervix and body.

December 10th. Indurations less marked, and the patient, feeling well, was discharged at her own request after being warned of the danger of relapse.

NOTE. If the first attack, six months after her labor, had been recognized, the recurrence of the disease might have been averted by proper treatment. It was possibly connected with the puerperal antecedents, though the enlarged uterus may have been very well attributable to the long-continued pelvic congestion.

CASE IV. *Pelvic Peritonitis; Obscure History; Probably Sexual Excess.* — C. F., twenty-five, single, entered December 24th, had one child at sixteen, labor natural. Has been sick a month with pain in back and bowels, mostly on left side and down the left leg. No rigors, no dysuria, no abdominal enlargement, some tenderness on pressure; knows no cause.

December 26th. Vaginal examination reveals a lacerated cervix and a mass behind the uterus the size of a large egg, reaching up into the hollow of the sacrum. Under fomentations, vesication, and applications of iodine externally, she gradually convalesced; remained in hospital for convalescence until February 4th, when she was discharged well.

CASE V. *Pelvic Peritonitis, of Long Standing and Recurrent; Probably Induced Originally by Abortion.* — H. B., forty-five, a widow; entered December 14th, menses at sixteen, always regular but painful; had two children, and two abortions induced by her-

self" with an instrument given by a doctor." Last pregnancy sixteen years ago; had an attack like the present seven years ago, otherwise well until three weeks since, when, two weeks after catamenial period, she took to her bed with severe abdominal pain extending down the thighs, which came on suddenly after a hard day's work in washing; no dysuria, no vomiting, chilly sensations not amounting to rigor, constant flowing for past two weeks.

December 15th. Vaginal examination shows the mucous membrane of the posterior wall ridged and hypertrophied and extending back for two inches, resembling an enlarged urethra. Rectal examination shows no pouching of the rectum, cervix uteri pushed forward by a large mass in posterior cul-de-sac, fundus retroverted, sound entering two and one half inches. The uterus was gently curetted, removing clots and some portions of mucous membrane, and causing slight pain; iodine applied to cavity. The flowing continued slightly up to the 24th, the time for her regular period, when it ceased entirely, instead of increasing.

December 31st. No recurrence as yet of the menstrual period. She is much improved and the effusion is rapidly absorbing.

January 4th. Mass reduced to size of an English walnut. She remained for convalescence until February 4th, when she was discharged well.

Case VI. *Pelvic Peritonitis, followed by Cellulitis and Chronic Cystitis.* — M. McC., thirty-one, single, entered August 17th, with history well marked, of peritonitis caused by cold at the menstrual period a year previously. Gave up work three months before entrance. Complains of lumbar pain extending to thighs, vaginal heat and leucorrhœa and irritable bladder. The urine contains pus. Pressure above pubes causes pain.

October 8th. Vaginal examination shows a virginal os uteri, the uterus freely movable and retro-

verted; remains of old cellulitis shown by several deep firm ridges stretching across the posterior cul-de-sac.

November 20th. Patient has decidedly improved during the six weeks since last date, under hot douches, counter-irritants, opiates, bladder injections, etc., but she is very nervous and irritable, complaining still at times of dysuria. The hard ridges in the cul-de-sac having become much softened, attempts to replace the fundus uteri were cautiously made, but she was unable to bear any form or size of pessary, or even cotton tampons, and after repeated trials they were discontinued, as they caused too much pain and general discomfort. She left January 9th, improved.

Note. A well-marked instance of chronic cystitis, uterine dislocation, neuralgic pain, and permanent injury to health from pelvic peritonitis, suffered to continue for a year without proper treatment.

Case VII. *Hæmatocele; Pelvic Peritonitis and Cellulitis: Extensive Effusion, either Serous, Sanguineous, or both.* — L. C., aged twenty-seven, widow, entered August 4th; has had one child and two miscarriages; menses began at thirteen, always painful but regular; has been sick for two or three months, with steady pain in back and through the bowels; almost continuous metrorrhagia, sometimes offensive; constipation and headache; at entrance pulse was 124, temperature 100° F. A hard nodule was found on the anterior lip of the cervix, bleeding easily. For ten days after entrance had diarrhœa. She continued with constant pain in lower abdomen, the metrorrhagia apparently diminishing, until October 2d, when, upon examination, I found the cervix pointing forward and to the left; behind the uterus, separated from it by a deep sulcus, a large, hard mass of effusion extending from the left to the right side of the uterus (but mostly on the right), and rising into abdomen nearly to the umbilicus. (See diagram.) Uterus fixed, no fluctuation bimanually nothing between uterus and bladder. Could bear but little pressure in supra-pubic region. She continued

with more or less of pain, vomiting, and dysuria until the 20th, when, on vaginal examination, a diminution of the effusion on the left side was noted, and also of the supra-pubic enlargement.

Fig. 1.

The Amount of Induration as shown by Abdominal Palpation.

November 22d. During the four or five weeks since last report has had some relief from fomentations and douches and free use of opiates; has had chilly sensations, but no rigor; no other evidence of suppuration. Vaginal examination now shows some farther diminution in the posterior mass and a slight extension of the induration to the front of the cervix. No fluctuation or softening.

December 7th had a recurrence of vomiting and severe pain. Vaginal examination now shows the left side to be comparatively free.

December 15th. The house officer was called during the night, and found her over the foot of the bed in a doubtful condition of convulsion; this was considered to be hysterical, and due to the free use of opiates, which from this time were much diminished. Three days later (the 18th) a surprising diminution of the effusion was found, and by the 23d only one very small spot of hardness, on the right of the uterus, remained. Being free from pain, and able to sit up, was allowed to go home.

Note. The hardness, the lateral position in the pelvis in the early stages, of the larger part of the effusion, would indicate peritonitis, and especially the late occurrence of cellular induration anterior to the uterus; but the metrorrhagia, the abdominal extension of the effusion, and the ultimate rapidity of absorption are more characteristic of hæmorrhagic origin, though

there was no marked anæmia. The rational supposition, it seems to me, is that the effusion was originally sanguineous, and that the inflammatory action was secondary.

Case VIII. *Endo-Cervicitis and Chronic Cellulitis; Menorrhagia.* — L. C., twenty-eight, single, entered August 25th. Has been sick a year with dysmenorrhœa, menorrhagia, metrorrhagia, and dysuria. Examination revealed a hard, irregular mass in the posterior cul-de-sac, movable with uterus. Catamenia have been always irregular and painful, with a free flow lasting ten to fifteen days; has leucorrhœa, occasional headache, and vomiting, and has lost flesh; abdominal tenderness, aggravated by stooping or defecation. Has never been pregnant.

October 2d. Vaginal examination reveals a small mass of induration, not tender, high up in Douglas's pouch, a general congestion of the cervix and upper part of the vagina, with the cervical mucous membrane, so far as visible, roughened and congested. Patient very nervous. The sound in the cervical cavity induced extreme pain.

November 1st. The effusion very much diminished. The sound still causes extreme pain.

November 12th. Menses came on and lasted but one day.

December 4th. Much improved. Now menstruating again, but less abundantly and with less pain than formerly. She continued improving under fomentations, douches, and scarifications of cervical canal until the 15th, when the effusion and the cervicitis had nearly disappeared, the fundus being slightly displaced by the adhesions latero-posteriorly.

December 19th. Well enough to be up and about, and was discharged at her own request.

Case IX. *Pelvic Hæmatocele; Suppuration; Artificial Opening through Posterior Wall of Vagina; Sac ruptured by Iodine Injection; Recovery.* — H. O'C., thirty-two, married, entered December 18th. A

clean, healthy-looking woman and mother of four children, the last four months old. Three months ago, during the first menses after her confinement, she was, without any traceable cause, suddenly seized with severe cramp and pain extending through the pelvis and loins, followed immediately by a rigor. Two days later had severe vomiting, and subsequently repeated rigor, with excessive abdominal tenderness and painful defecation. Had no dysuria for first four weeks. Continuous menorrhagia until three weeks before entrance. Has never discovered any supra-pubic enlargement. Pulse 104; temperature 100.6° F. The cervix was found far forward and fixed; a large boggy, fluctuating mass, not sensitive, was found behind the uterus and pressing upon the posterior vaginal wall. A large trocar gave vent to one ounce of thick, bloody, offensive fluid, mixed with small coagula. Carbolic water was injected until it returned clear. The tumor was but slightly reduced. The following day she was perfectly comfortable, with a free, colored discharge.

December 20th. Again washed out.

December 22d. The opening was enlarged to an inch with a metrotome, and offensive coagula removed; daily injections ordered.

December 26th. The washings still bring away much offensive matter. The injections cause no pain, and she is in every way comfortable.

December 30th. Discharge much less offensive and nearly colorless. Depth of sac reduced to one and a half inches.

January 3d. Healthy pus only discharged. Tincture of iodine, one to two drachms, injected without pain.

January 11th. The discharge not diminishing, iodine was again injected, but was now followed instantly by great pain and collapse, feeble pulse, cold extremities, and sweating. The pain was most severe over the epigastrium, though she complained of burning throughout the abdomen. Stimulants, hot fo-

mentations, and morphia subcutaneously soon gave relief, though she had three slight rigors during the day.

January 12th. Complains a little of her stomach and of a "bad strange taste" in her mouth, but slept fairly, and is perfectly comfortable. No fever.

January 17th. The orifice was stretched with sound to prevent closure. The discharge soon ceased almost entirely, no induration remaining, and she left, well, January 23d.

NOTE. In this case the opening was made just as suppuration was commencing. If left to itself it would probably have discharged into the rectum and been followed by a long and exhausting pelvic abscess, with cellulitis, plastic exudation, and the usual sequelæ of displaced and adherent organs. This is the second instance in which I have known injections of the sac to be followed by symptoms of rupture into the abdominal peritonæum. In both iodine was used, late in the disease and after repeated previous washings with water, alone or carbolized. In neither instance did any serious result follow, though it must be confessed that the symptoms were sufficiently alarming at first to impress one with the necessity of extreme caution and gentleness in such cases.

CASE X. *Chronic Puerperal Pelvic Abscess following Labor Sixteen Years ago; repeated Acute Attacks, with Openings into Bladder and Vagina.* — F. H., forty-four, widow, entered September 6th. After delivery by instruments sixteen years ago she had "inflammation of the bowels," probably cellulitis. About every six months for the past thirteen years she has had attacks of rigors, with great pain in the pelvis, and other symptoms of pelvic inflammation, lasting for ten days or more. She was in the hospital three years ago, her history at that time being one of both vaginal and bladder opening. Since that time has had no more "leucorrhœa," which had previously been abundant at times, and no more of these recurrent attacks

until the present. The menopause occurred twelve months since.

October 2d. A dense band of cicatricial tissue is found stretching across the vagina in front of the cervix, but not obliterating the passage. Some inflammation and thickening of the vaginal vault, but no positive induration is discoverable, either by vaginal or rectal examination.

October 8th. A rigor occurred, followed by vomiting, abdominal pain, and irritable bladder, with a large quantity of pus in the urine. This acute suppurative process, with abundant discharge of pus from the bladder, continued for many weeks. The symptoms, however, all gradually subsided, and she left the hospital November 14th, much relieved, though the urine still contained some pus.

Note. This case is a good illustration of the miserable condition of many patients who are supposed to "recover" from pelvic abscess. Whether the vaginal cicatrices were significant of previous openings into the vagina, or whether they resulted from injury at the time of her labor and were the *point de départ* of cellulitis and abscess at that time, can only be conjectured. The "leucorrhœa" was possibly pus from an abscess opening formerly into the vagina.

Case XI. *Recent Puerperal Pelvic Abscess, opened in the Groin; Bronchitis, etc.* — A. D., aged twenty-one, married, entered September 21st. Nothing unusual in her menstrual history; has been married two years; has had one miscarriage, and one month before entrance was delivered at full term, leaving her bed in two weeks feeling well. Directly on getting about, however, was attacked with vomiting, rigors, diarrhœa, dysuria, and abdominal pain. The vomiting still continues. Temperature 102° F.; pulse 120. The lochial discharge ceased a few days before entrance. Examination shows absolute rigidity and solidification of the pelvic roof, the uterus immovable, and the abdomen tender in the supra-pubic region. She soon be-

gan to reject all food and stimulants, and a small bed-sore appeared on the sacrum.

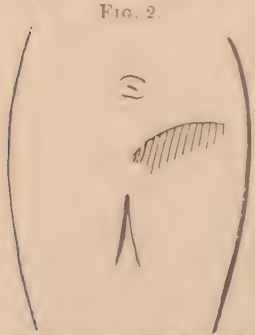
October 6th. The vomiting and great prostration have continued until date, and she has been nourished by enemata. To-day she is able to retain one teaspoonful only at a time.

October 8th. Abdomen softer, but still very tender.

October 13th, a large slough half an inch thick and nearly two inches in diameter was removed, leaving the sacrum exposed and an extensive, deep, undermined ulcer, four to five inches in diameter. She has large aphthous patches on the tongue and cheeks, involuntary dejections, and retains nothing but small doses of beef extract. For two days has had severe inflammation of the throat, with aphonia.

October 10th. Though the abdomen was very tender, by gentle palpation the induration was traced above Poupart's ligament on the left side one third way to the umbilicus. (See diagram, Figure 2.)

Fig. 2.



Situation and Extent of Effusion as shown by Abdominal Palpation October 10, 1881.

October 15th. Able for the first time since October 1st to make a vaginal examination. A large mass was now found filling the left pelvis and extending above Poupart's ligament a third of the way to the umbilicus, hard and resisting, and with no signs of fluctuation discoverable, but on the 17th a doubtful spot above Poupart's ligament was opened with the bistoury, and yielded a small amount of fetid pus. This opening was poulticed, all pressure being carefully avoided.

October 18th. More comfortable. Abscess discharging slowly. Has now cough, with abundant sonorous and sibilant rales. She, however, continued to

improve for a week, when she had a relapse of vomiting, caused by improper food. From this time improvement was uninterrupted. After discharging freely the opening closed, and, the sac not refilling, December 4th was able to sit up.

December 31st. Uterus was found to be movable, with very slight posterior adhesions, no remains of induration or swelling to be found, and the large sacral sore nearly closed. She was allowed to remain in the hospital for a time to regain her strength. When able to leave her bed she found herself with partial loss of both motion and sensation in the lower extremities, which it required nearly two months to recover from, probably from granular muscular degeneration after such protracted high temperature.

NOTE. The suddenness of the attack when apparently well and two weeks after a normal confinement would suggest a hæmorrhagic origin, but whether hæmorrhagic or septic the early pointing and evacuation doubtless saved her from extensive consolidation of the pelvic tissues, and probably from much future trouble, as there remains no discoverable induration by external or internal examination in the lateral regions of the pelvis. The uterus is freely movable, the posterior adhesions being too trifling to cause any interference.